LOS ANGELES COUNTY COMMISSION ON HIV

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COMMISSION ON HIV
MEETING MINUTES
December 12, 2013

MEMBERS PRESENT	MEMBERS PRESENT *(cont.)*	MEMBERS PRESENT *(cont.)*	DHSP STAFF
Michael Johnson, Esq., *Co-Chair*/ Kevin James Donnelly	Sharon Holloway/ Ismael Morales	LaShonda Spencer, MD	Kyle Baker
		Harold Sterker, MPH	Ryan Murphy
Ricky Rosales, *Co-Chair*	David Kelly, MBA, JD	Jason Tran/Rob Lester, MPP	Amy Wohl, PhD
Alvaro Ballesteros, MBA	Ayanna Kiburi, MPH *(by phone)*	Monique Tula	Juhua Wu, MA
Raquel Cataldo	Lee Kochems, MA	Fariba Younai, DDS	
Fredy Ceja, MPA/ Jose Munoz	Bradley Land	Richard Zaldivar	
	Ted Liso/Douglas Lantis, MBA		
Michelle Enfield	Abad Lopez		
Lilia Espinoza, PhD	Marc McMillin		
Dahlia Ferlito, MPH (pending)	Victoria Ortega	**MEMBERS ABSENT**	**STAFF/CONSULTANTS**
Suzette Flynn	Angélica Palmeros, MSW		
Lynnea Garbutt	Mario Pérez, MPH	Joseph Cadden, MD	Dawn McClendon
David Giugni, LCSW	Gregory Rios/ Jenny O'Malley, RN, BSN	Pat Crosby	Jane Nachazel
Terry Goddard, MA		Aaron Fox, MPM	Glenda Pinney
Grissel Granados, MSW/ Maria Roman	Juan Rivera	AJ King, MPH	LIse Ransdell
	Jill Rotenberg	Mitchell Kushner, MPH, MD	James Stewart
Joseph Green/ Erik Sanjurjo, MA	Sabel Samone-Loreca/ Susan Forrest	Patsy Lawson/ Miguel Palacios	Craig Vincent-Jones
			Nicole Werner
Anthony Gutierrez, MA	Shoshanna Scholar	Terrell Winder	
Kimler Gutierrez (pending)	Terry Smith/Gambit Geniess		

PUBLIC			
Rich Abe	Stephanie Hayes	Laura Ramos	Tzeli Triantahllon
Herman Avilez	Uyen Kao	Tania Rodriguez	Jason Wise
Margarita Barragan	Gabrielle Leon	Martha Ron	
Chris Blades	Mia Mays	N. Sanchez	

1. **CALL TO ORDER**: Mr. Rosales opened the meeting at 9:30 am.
   - **A. Roll Call (Present)**: Ballesteros, Cataldo, Ceja/Munoz, Enfield, Espinoza, Ferlito, Garbutt, Giugni, Goddard, Granados, Green, Anthony Gutierrez, Kimler Gutierrez, Johnson/Donnelly, Holloway/Morales, Kelly, Kochems, Land, Liso/Lantis, Lopez, McMillin, Rios/O'Malley, Rivera, Rosales, Rotenberg, Samone-Loreca/Forrest, Scholar, Smith/Geniess, Spencer, Sterker, Tran/Lester, Tula, Zaldivar

2. **APPROVAL OF AGENDA**:
   MOTION 1: Approve the Agenda Order with Item 8, Executive Director's Report, moved after Item 15 ***(Passed by Consensus)***.

3. **APPROVAL OF MEETING MINUTES**: Mr. Stewart noted minutes can be corrected at any time in the future.
   - **A. April 11, 2013:** Mr. Vincent-Jones noted a transcript of the colloquium was also in the packet and will be made into a publication in future. Minutes were not available for review prior to the meeting.
   - **B. October 10, 2013:** Minutes were not available for review prior to the meeting.

C. November 14, 2013: Mr. Vincent-Jones noted these were distributed in advance for review, but Mr. Smith said he only received them the prior afternoon so had not had time to read them.

MOTION 2: Revise and approve the minutes from the April 11, 2013 Joint Commission on HIV/Prevention Planning Committee (PPC) meeting, the October 10, 2013 Commission on HIV meeting and the November 14, 2013 Commission on HIV Annual Meeting, as presented ***(Postponed)***.

4. **PUBLIC COMMENT, NON-AGENDIZED OR FOLLOW-UP**: There were no comments.

5. **COMMISSION COMMENT, NON-AGENDIZED OR FOLLOW-UP**: There were no comments.

6. **CONSENT CALENDER**:

A. Policy/Procedure #08.2107: Consent Calendar:

- Mr. Johnson noted that all of the items on the Consent Calendar had been pulled due to technical difficulties reproducing the accompanying information for the packets. He explained that the Consent Calendar improves meeting efficiency by allowing a subset of all of the motions in a meeting where there is already consensus support to be approved as a single motion.
- Motions can only be included on the Consent Calendar if there is no presentation or discussion planned for the agenda item and no one (including the public)c wishes to discuss the items, e.g., an item might pertain to a policy/procedure previously discussed and opened for public comment that received no comments and had no changes.
- Motions accompanied by a planned presentation or about an issue that requires a roll call vote (e.g., priority- and allocation-setting) are always removed ("pulled") from the Consent Calendar at the start of the meeting. Any Commissioner or member of the public can also pull an item from the Consent Calendar because he/she wants to discuss it at its appropriate time on the agenda.

MOTION 3: Approve the Consent Calendar ***(Postponed)***.

MOTION 4: Approve Policy/Procedure #08.2107: Consent Calendar, as revised and presented following public comment period ***(Postponed)***.

7. **CO-CHAIRS' REPORT**:

A. Community Member/Alternate Committee Assignments:

- Mr. Johnson noted that the prior Commission could allow community members with special expertise to serve on committees as voting members. Each committee, however, must first decide if it wanted the appointment of such members to its body.
- There is also an opportunity for Alternates to serve on committees other than those to which their Commissioner has been assigned. Many Alternates have a high degree of professional or consumer expertise, but are often do not play as active a role as they could to because the Commissioner to whom they have been assigned is regularly attending his/her assigned committee meetings and acts and votes on behalf of the seat (there is only one vote per membership seat). By serving on other committees with secondary committee assignments, Alternates have the opportunity to participate in Commission activities more independently than the Alternate assignment may allow them at times.
- The Executive Committee will be discussing these subjects, but all committees are asked to evaluate their needs.
- ➲ Policy/Procedure #09.1007: Community Member Appointments, will be distributed by email and will be open for public comment until 1/31/2013.

B. Commission Representation to UCHAPS:

- Mr. Rosales reported that the Urban Coalition for HIV/AIDS Prevention Services (UCHAPS) met in Los Angeles earlier in the month. UCHAPS assembles the highest impacted jurisdictions for mutual support, technical assistance and best practices. Current members are: Atlanta, Baltimore, Chicago, Fort Lauderdale, Houston, Los Angeles, Miami, New York, San Francisco and Washington DC.
- Much of the last meeting's discussion centered on how to use data to improve programming with various jurisdictions explaining their activities. Another major topic was on the integration of planning groups. Los Angeles and Chicago discussed their unification processes. San Francisco discussed their unsuccessful experience trying to move towards a single planning council.
- Jurisdictions must send a list of representatives and designate a Steering Committee representative each December.

- Mr. Baker, DHSP, served as a government representative from LA County on the Steering Committee for the past two years. Last year's representatives to UCHAPS from LA County had decided that steering committee representation would alternate between government and community representatives every two years. Mr. Rosales was selected to succeed Mr. Baker as the Steering Committee representative at the conclusion of his term in the Fall.
- Each UCHAPS jurisdiction sends two government representatives and an alternate and two planning group representatives and an alternate. In the past, the PPC designated its two community co-chairs as the community representatives and the body elected the alternate. The Commission has not yet established a policy, so the Executive Committee agreed to follow precedent: Messrs. Rosales and Johnson will serve as representatives to the UCHAPS Steering Committee, and the Executive Committee unanimously elected Mr. King to continue serving as the community representative alternate.

➲ The Operations Committee will develop a Commission policy for use starting next year.

C. Commission Representation to California Planning Group (CPG):

- Ms. Kiburi said the Office of AIDS (OA) does not want to close membership until it has a representative from each of the State's eight planning councils. Three planning councils, including Los Angeles, had not yet nominated representatives. The original deadline had passed and applications were now requested as soon as possible. An application was included in the packet.
- Mr. Zaldivar asked about ethnic/racial balance of existing MSM candidates. She added that current membership applications did not adequately reflect candidates who are MSM of color, and any additional applications that reflected that membership category would be considered. Likewise, they needed an additional reviewer of the applications and felt that someone from Los Angeles County would add balance to the membership review.
- Mr. Vincent-Jones noted the CPG has two types of members: general members who are not specifically representing the planning councils and one representative from each planning council. Los Angeles may have other representatives, but only one who can speak for the planning council. He suggested selecting at least a tentative nominee during the meeting. A vote this month or next would be needed.

MOTION 4A (*Zaldivar/Rosales*): Move discussion on CPG representation to the OA report ***(Passed by Consensus)***.

D. Organizational Development: Six (6)-Month Post-Unification Assessment of Progress:

- Mr. Johnson reported the last Executive Committee meeting discussed organizational issues and chose to engage Diane Burbie, The Aspire Group, and her associates to facilitate team-building exercises. The goal is to ensure Commissioners can all contribute their skills in the most effective manner possible in the process of building a new Commission culture.
- Mr. Rosales added the Executive meeting discussion was a first check-in on how the integration process is progressing. Team-building exercises will add input for continuing discussion on strengths, weaknesses and possible improvements.
- Ms. Ransdell said she and Ms. Burbie do significant work in organizational development, group dynamics and helping groups improve their effectiveness. The goals or team-building exercises are to improve productive discussion and decision-making processes.
- There are factors that can support effective group work, such as clarity of purpose and commitment to participate. Other factors can hinder the group process, such as frequent membership changes and poor participation. Some factors can help or hinder depending on how aware a group is of them, such as how we communicate as individual participants/members.
- Ms. Ransdell has a background in interactive and experiential activities, the focus of the exercises. Commissioners and many of the public moved to the room's center. Signs at opposite ends of the room were: "True for me;" and "Not true for me." Participants moved toward the pertinent sign for them for each of a series of statements on communication:
  - In a group, I find I am often the first to speak.
  - I generally wait to be invited to speak.
  - I step outside my comfort zone when I speak in a large group.
  - In a group, I prefer to wait to speak until others have spoken.
  - I really enjoy engaging in a good argument.
  - I am accustomed to communicating in more than one language.
  - If silence goes on too long, I will sometimes jump in just to fill it.
  - In a conversation or discussion, I can get impatient when people don't respond promptly.
  - Arguments and conflicts leave me feeling stressed and exhausted.
  - I will readily say what I feel even if I know others won't like it.

- When I talk, I like to enhance with context or background.
- I often find myself holding back what I might say because of how it may be perceived.
- I take time to think about what I'm going to say before I say it.
- I can go from topic to topic without thinking.
- I appreciate others' interjections and opinions.
- I appreciate others' interjections and opinions when I'm talking.

- One person found it interesting that people she thought had a high comfort level when speaking in public did not. Another noted she was nervous about it growing up, but gained confidence with experience. Comfort levels may vary depending on the group. One participant felt a responsibility to speak because otherwise the communities he serves would not be represented.
- Mr. Johnson said "language" to him included not just languages such as English or Spanish, but technical or topical speech. Regarding arguments, he personally hates to fight despite his background as a litigator, but he puts a kind of armor to meet his responsibility and duty to consumers, to make a system more effective or as a client. He is then willing to argue as long as it is productive because those are the dynamics and languages he can use.
- Another participant said hearing someone use other languages, such as technical speech or Spanish, helps him understand the speaker culturally and helps him stay open to what they are saying.
- Ms. Ransdell noted people have individual preferences about the amount of silence that is comfortable. Different situations also have an impact and some cultures honor silence more than others.
- Mr. Land said he can become impatient when people he knows to have important skills or expertise that could benefit a conversation do not participate. He does not like to push people to participate, but tries to encourage it. However, as another noted, some people need time to process information. If pushed to respond, they may shut down.
- Ms. O'Malley said she was trained as a nurse to seek an immediate intervention to address a problem. She has matured to realize it is important to develop a thoughtful, genuine, respectful response. Mr. Stewart added both speaking and silence have consequences.
- Mr. McMillin noted context is often missing today so he appreciates it, but another person preferred a direct answer. Ms. Ransdell noted our culture supports getting to the point or topic quickly, but other cultures consider that rude.
- One participant noted he may hold back on saying something not because of possible consequences, but because he feared overstepping in a group. Mr. Johnson said the Commission provides roles such as advocates, planners or co-chairs. Everyone has a role. The purpose of the organizational work is to better define these various roles and how they work together for the good of the body.
- Ms. Ransdell noted most people like others to offer opinions, but not by interrupting. It is key to evaluate whether a thought is supportive or an impediment. Ms. O'Malley added her train of thought is disrupted when she is interrupted.
- Anthony Gutierrez said the rules of engagement are important for group effectiveness since different people have different approaches. He wants feedback, not dead air, but in an orderly framework. Mr. Johnson added that, while the Commission has a formal process governed by the Brown Act, people should not let the process deaden conversation. Mr. Liso stressed the importance of using active listening to support appropriate interactions.
- Mr. Rosales reminded everyone to fill out the assessment forms for the exercise to inform further activities.

E. Organizational Development: Six (6)-Month Post-Unification Assessment of Progress:

- Mr. Johnson announced he left Planned Parenthood on 11/30/2013 after two years. His new contact information will be included on the new Commission contact list that will be distributed to Commission members shortly.

8. EXECUTIVE DIRECTOR'S REPORT:

A. Pol/Proc #06.1000: Commission Bylaws:

- Mr. Vincent-Jones reported Bylaws were first presented two months ago for review. Revisions pertain to two areas.
- The first simply eliminates the "PP" abbreviation for the Public Policy Committee wherever it occurs.
- The second area concerns whether or not DHSP would have formal, appointed representatives with voting rights on committees. DHSP had suggested not having representatives due to concern they may need to abstain, but that mainly pertains to Public Policy. They were also concerned about attendance from DHSP representatives affecting quorum, but it was noted that failure to achieve quorum is the result of a majority of members not attending, and DHSP representatives have never exhibited a regular pattern of not attending meetings, in spite of occasional absences.
- Operations considered the issue. It felt formal representation offers a particular benefit when the planning group and grantee agree on issues, on the record. The Commission did not find abstentions were that common, with the

exception of policy; but the Committee felt that, across the Commission, abstentions could be better explained. Members are not required to explain them, but it is helpful for other members to understand why one of their colleagues is choosing to refrain from the final decision on important issues.

- It was agreed that, as previously, Priorities, Planning and Allocations (PP&A); Public Policy; and Standards and Best Practices (SBP) would have DHSP representatives. Operations will not since its subject matter is internal organization.
- Operations agreed DHSP could opt to have two PP&A and SBP representatives to reflect care and prevention perspectives. Language is therefore written as "up to two representatives – one each from the prevention and care perspective." Those provisions have been inserted in the respective committees' sections, which was communicated to DHSP.
- Mr. Zaldivar asked if the vote should be deferred to allow more review, but Mr. Vincent-Jones noted the two-month public comment period prior to the meeting, with only minimal revisions as noted and no other comments. The Commission is working to shift its operating model so materials are distributed before the meeting, but this policy has been available for review, the issue had been highlighted when it was introduced, and further time would only delay a final disposition without, he doubted, much, if any, understanding accorded due to the extra time.

MOTION 5: Approve amendments to Policy/Procedure #06.1000: Commission on HIV Bylaws, as revised and presented following public comment period ***(Passed by Consensus)***.

B. HRSA Webinar: PC/HPG Integration:

- Mr. Vincent-Jones reported the Los Angeles County Eligible Metropolitan Area (EMA) was invited to participate in a webinar on the unification process. Chicago also participated. It is the only other Part A jurisdiction to engage in such a process, but used a very different approach. Both presentations were in the packet.
- Emily Gantz McKay assisted the Commission with unification as part of a Technical Assistance (TA) contract. She wrote a manual at HRSA's request on the process and lessons learned. It is being used as a TA manual for other jurisdictions considering unification. The manual is available at the Target Center.

C. Staffing Pattern:

- Mr. Vincent-Jones announced Ms. Pinney will be transferring to Substance Abuse Prevention and Control (SAPC), Department of Public Health (DPH). Although they did not have a final date for the transfer, she was likely to leave prior to the next meeting so he wanted to publicly thank her for seven years of commitment and work for the Commission. The body applauded her in appreciation.
- The Commission is proceeding to fill three existing vacancies. The first hire will likely be a Research Analyst III who will be the principal lead for the Commission on the Los Angeles Coordinated HIV Needs Assessment (LACHNA) and other research, as well as serve as the Commission's liaison with DHSP's surveillance, research and related units.
- Interviewing will begin in early 2014 for two other positions, one mid-range coordinator level and the other a support staff position. Subsequent to filling those positions, Mr. Vincent-Jones expects to request an additional managerial item (position) from the CEO.

D. Miscellaneous: A Colloquia work group will address topic selection and format. Members are: Mr. Lester, Ms. Rotenberg and at least one representative each from DHSP and the Center for HIV Identification, Prevention and Treatment Services (CHIPTS). Others are invited to join the work group if interested.

9. **PARLIMENTARY TRAINING**: Mr. Stewart said training on parliamentary procedures is planned for 2014.

10. DIVISION OF HIV/STD PROGRAMS (DHSP) REPORT:

A. HIV Epidemiology Report: There was no report.

B. Administrative Agency Report:

- Mr. Pérez noted the application season has passed, but DHSP does not yet know what its full funding awards will be in most instances. There is a recommendation by the CDC to fund the STD response at approximately a $3.5 million.
- Overall, DHSP manages approximately $100 million. $5 to $6 million was cut in the last Federal funding cycle, but DHSP has been able to avoid service cuts so far. Additional cuts are expected with funding likely to drop to $90 million.
- The majority of those funds are HIV-specific so it is important to be aware of other resources. In lieu of the intersection of HIV and STDs, $3.5 million is insufficient for an effective response and DPH lacks sufficient funds to compensate. The private health care sector, particularly in the era of the Affordable Care Act (ACA), must play a critical role.

- The CDC also runs the Gonorrhea Isolate Surveillance Program (GIS) which provides a couple of hundred thousand dollars nationwide to increase health department capacity to monitor for resistant strains of Gonorrhea. Los Angeles received $5,000 for GIS. San Francisco received $10,000 as did those who manage the California CDC Control Branch.
- DHSP is working with the State to determine if the $25,000 total might be managed as a whole by the State. That would reduce administrative costs. Otherwise, Los Angeles will need to spend more than the $5,000 it receives for the costs of the program.
- The issue also speaks to DHSP concerns with how the CDC thinks about resource allocation. It is most likely Gonorrhea resistance will develop on the West Coast first if it develops in the Unites States, so resources should be focused here.
- Mr. Land noted there had been approximately $19 million moved forward for prevention on the Board agenda in the last few weeks. He asked about the PPC role in those allocations, which he indicated cover one or more years. Mr. Pérez said DHSP did forward several Board letters recently. They were continuation of current prevention activities, and all were approved.
- The largest renewed all HIV testing programs with refinements to increase new diagnoses versus the total testing HIV+. In the past, as many as 40% of the total had already been diagnosed and should have received other interventions, such as linkage to care. Goals are to increase: volume, the identified positivity rate to meet thresholds, and to link those testing HIV+ to medical care/partner services. DHSP asked the Board to consider contracts with a broad group of providers aimed at those goals. Contracts use hybrid financing with a cost reimbursement portion and a pay-for-performance portion to incentivize progress.
- DHSP also asked to extend the contract with KCBS which shepherds multiple social marketing efforts. DPH has migrated to a consolidated social marketing vendor, but DHSP was in the midst of several efforts so wanted to complete them.
- A California Family Health Council (CFHC) contract was also extended for one year. Historically, as part of the STD grant, the Federal government required a minimum designated portion of funds be invested with the local Title X agency in the grantee's state. Family planning Title X funding often has a local administrator or Technical Assistance provider. CFHC is the local provider and has been a key STD partner. DHSP is in the first of a five-year grant, so asked to extend.
- The Board was also asked to accept the grant for the STD response, which is expected in the next few months. The approved contracts total approximately $20 million with several multi-year. In early February, DHSP will request approval on contract renewals for approximately 60 care and treatment categories while DHSP develops new RFPs.
- Planning around the HIV portfolio is changing. The single largest expense for any service in the County is $20 million per year for HIV medical care for PLWH without other insurance. DHSP migrated to Fee-For-Service (FFS) so is now paying providers for units of service provided to eligible PLWH after screening out those eligible for Medi-Cal or private insurance. It is historically the tightest eligibility screening for the program funding.
- We are now in a transition with the number of those who qualify for Ryan White-funded services declining due to their eligibility for Medi-Cal or Covered California under the ACA. The Commission must decide soon how to invest resources that are no longer needed for medical care, e.g., identify areas to enhance and the level of wrap-around services to fund for those migrating to plans which only cover medical care and some other types of care. Ryan White cannot cover medical care for those with other insurance, but could be used, e.g., for medical transportation.
- Also, as the overall operating budget for services decreases, it is necessary to decide how to retool the prevention tool box, e.g., less or more biomedical interventions. The next 18-36 months will be a rolling planning process with many changes in Federal and State funding levels, as well as reauthorization and Maintenance of Effort issues.
- Ms. Tula asked about PrEP, especially for sex workers. Mr. Pérez noted DHSP continually reviews prevention tools. There is approximately a 72-hour window period after exposure during which PEP can be initiate effectively. The 28-day course of antiretroviral therapy costs approximately $1,000. The two PEP sites are at the Oasis Clinic and the Gay and Lesbian Center (GLC). A 12- to 15-month study a few years ago resulted in just two seroconversions out of 285 people. The programs are effective so the goal is to grow PEP, but the program are expensive despite being cost-effective in reducing lifetime costs.
- PrEP is designed to avert infection for those who are at the highest risk of HIV infection or in a high-risk period of their lives, e.g., sex workers. Much like birth control, patients take a pill daily. PrEP is not now formally supported as part of the prevention tool box, but the County has the largest number of ongoing studies nationwide. Studies are examining the acceptability, feasibility and cost effectiveness of PrEP as a permanent prevention option in the tool box.
- A January meeting of PEP and PrEP partners will assess progress of studies, preliminary results and begin discussion on formal recommendations. There are also talks with a pharmaceutical partner to identify opportunities to reduce costs.

- Mr. Kelly noted Mr. Pérez presented on STDs prior to integration, but recently considered pulling some DHSP staff from committees. He asked if enthusiasm had waned and how to best rekindle it. Mr. Pérez said DHSP is very motivated to think critically and comprehensively about the HIV/STD response. He had and did strongly advocate for integration.
- Mr. Zaldivar urged remembering the drain on all our systems due to legal actions and the consequence inevitably impacts interactions.
- Ms. Scholar asked about syringe access. Mr. Pérez said he is a strong advocate and proud of needle exchange sites he helped establish in the 1990's. The annual Ryan White application is in response to a Federal guidance and is limited to 80 pages. DHSP thinks through points for each section to maximize them. The current guidance does not include some prevention elements. It does ask how the jurisdiction is working with PLWH, e.g., to enhance prevention with positives.
- Applications that can address the entire HIV continuum are preferable and the CDC application does a better job of describing the role of syringe access programs. They are also discussed in the Comprehensive HIV Plan.
- Mr. Johnson reminded Commissioners that Ms. Werner emails Board Agenda information weekly for review. Every contract or modification over $10,000 is included. They reflect implementation of Commission decisions.

1. ***FY 2014 RW Part A Application***:
   - Mr. Pérez encouraged Commissioners, especially those new to care and treatment, to read the application. It is an excellent primer on the context in which work is done, jurisdiction goals and areas where we are making progress, not making as much progress as possible or where there are significant racial and ethnic disparities.
   - The Administrative Agency Report is also included as part of the application.
2. ***FY 2014 CDC Cooperative Agreement***: There was no additional discussion.
3. ***Presentation: "Overview of LA County's STD Prevention and Control Activities"***:
   - Mr. Rosales introduced the overview noting the Commission chose to include STD oversight as added responsibility, at DHSP's urging, when the two planning bodies unified.
   - Mr. Pérez noted Jonathan Fielding, MD, MPH, Director of Public Health and Health Officer, decided to integrate the former Office of HIV Epidemiology, the former STD Program and the former Office of AIDS Programs and Policy into a single Division of HIV/STD Programs (DHSP) in February 2011. Since then, DHSP has worked to peel back layers and look at historical responses, epidemiology trends and STD tools to enhance the STD response.
   - He has been with DPH 14 years and has personally seen a remarkable increase in the level of critical review, epidemiology analysis and mapping sophistication for STDs. Much of that is due to Dr. Wohl and Mr. Murphy whose energy and expertise has helped paint a better picture. Some were dubious about the DHSP integration, but Mr. Pérez felt it had helped leverage many years of HIV expertise into a dramatically improved STD response.
   - Starting with trends, Mr. Pérez noted the County has the second highest number of PLWH in the nation. It has the highest number of people with some STDs. There were 69,979 STD and HIV/AIDS cases reported in the County in 2012 with 74.4%, Chlamydia; 17.5%, Gonorrhea; 4.9%, Syphilis; and 2.9%, HIV/AIDS.
   - DHSP is comfortable placing HIV/AIDS in the larger STD rubric because most HIV in the County is sexually transmitted. The County has done a remarkable job in averting transmission to injection drug users.
   - Syphilis is broken out into subpopulations along its continuum: primary and secondary (P&S), 1.4%; early latent, 2.0%; late latent, 1.5%; and congenital, 0.0% (6 cases in 2012). Congenital cases declined from 20 a few years ago. Nevertheless, Dr. Gail Bolan, Director, Division of STD Prevention, CDC, basically intimated the prior month that any county with one case of congenital syphilis has failed. DHSP is trying to dissect the context for the 2012 cases.
   - Rates for the four morbidities are broken out by ethnicity and male/female. DHSP wants to break data out by male-to-female and female-to male transgender, but data comparable to that for STDs is not yet available. DHSP has instituted a policy mandating transgender data reporting for STDs so it will be incorporated soon.
   - Rates are for cases reported in 2012 per 100,000, e.g., approximately 1,300 African-American females of every 100,000 were diagnosed with Chlamydia. Each morbidity uses a different scale, e.g., Chlamydia uses 0 to 1,500 while P&S syphilis uses 0 to 40. Rates are valuable in clarifying infection patterns within a population since ethnic populations vary in size, so absolute numbers may not reflect a morbidity's impact within a community.
   - The PowerPoint also provided a comparison of Chlamydia in the County versus the US gonorrhea and P&S syphilis rates for 2007 to 2012. Mr. Pérez noted that data is often requested, but is not the best comparison. The County is more comparable to urban areas such as Chicago, New York and San Francisco with similar circumstances, e.g., racial/ethnic diversity, population density and health care access.
   - 2011 Chlamydia, gonorrhea and P&P syphilis rates per 100,000 were also provided for a select number of comparable urban areas. County rates not including Long Beach and Pasadena are: Chlamydia, 512.9; gonorrhea,

103.4; P&S syphilis, 8.1. Philadelphia County rates are notably higher: Chlamydia, 1,332.3; gonorrhea, 440.0; P&S syphilis, 13.5. Houston rates are comparable, though higher, as are more concentrated areas such as San Francisco.

- We think about HIV in the context of how it impacts men, women, trangenders and racial/ethnic populations, e.g., gay men disproportionately shoulder the burden of HIV in the County. STD trends are also viewed in that context:
  - ⇨ Chlamydia overwhelmingly impacts women, particularly young women and young women of color;
  - ⇨ Gonorrhea impacts men and women more evenly, but African-Americans are very disproportionately impacted;
  - ⇨ Syphilis overwhelmingly impacts men, especially gay men. The proportion of MSM and MSMW with P&S syphilis who are co-infected with HIV consistently remains at approximately 50%.
- Chlamydia, gonorrhea and syphilis are all treatable and curable bacterial infections. The challenge is that treating the diagnosed person without identifying and treating the partner(s) leads to re-infection. It is critical to break that cycle, e.g., for the HIV community of providers to assess whether they do enough to diagnose and treat syphilis.
- Syphilis can be viewed in terms of less or more than 12 months. Primary and secondary and early latent occur in the first 12 months and may collectively be called early syphilis. Late latent syphilis usually occurs after 12 months.
- 2012 data shows those over 30 have higher rates of P&S syphilis/HIV co-infection. That may be an artifact of HIV infection later in life, but that is unclear if both are diagnosed simultaneously. Overall, there are high levels of co-infection confirming that infections move together. 2012 Chlamydia rates show major impact in SPAs 1, 2, 3, the south side of 4, large areas of 6, the Long Beach metro area of 8, and a few other high burden areas, e.g., Pomona.
- Ms. Tula asked about correlations with incarceration rates for men of color. Mr. Pérez said it was a factor, but not exclusively. Poverty is critical, as is age—given the many young people with STDs. DHSP has worked with GLC for 10 months to diagram a social/sexual network of young MSM in West Hollywood with syphilis, multiple partners and meth use.
- There are approximately 47,000 annual cases of Chlamydia; 10,000, gonorrhea; and 3,000, syphilis. The latter are primarily in Long Beach and portions of SPA 4.
- DHSP is working to develop a better epidemiological picture of STDs including its co-factors. It is known how drivers such as alcohol abuse tie into high risk sexual behavior, but data must be built into the systems. Consequence cycles also need to be built in for those not fully reporting on STD morbidity forms. The HIV world offers lessons that can be adapted to STD reporting to help planning bodies make more informed allocations.
- Integrated data is the goal. DHSP supports approximately 140,000 HIV tests annually. A growing number of venues offer both HIV and STD services. There are: 12 Public Health STD clinics, 28,275 tests; 1 community-based STD clinic at GLC, 69,685; 5 Community Wellness Centers with 4 at AIDS Healthcare Foundation (AHF) and 1 at AIDS Project Los Angeles, 47,680; 4 mobile testing units, 5,497; 11 commercial sex venues via an ordinance which prompted venues to hire JWCH for testing, 2,752; 1 storefront testing site, GLC, 1,000; 2 County jails, K6G at Men's Central Jail for openly gay and transgender inmates and the women's Central Regional Detention Facility, 14,620.
- Venues reflect different testing volumes and morbidity levels, e.g., K6G has high diagnosis and treatment rates.
- Mr. Lopez asked about meningitis. Mr. Pérez said it is not considered an STD as it is not transmitted sexually for the most part. He did not have data on it that day, but could discuss it at a later time.
- Data was drawn from the Medical Monitoring Project (MMP), 2009 to 2010, on STD screening in the last 12 months in sexually-actively HIV+ patients in care at a representative sample of all HIV providers. There were 402 men in the MMP, but 291 reported being sexually active so percentages are tied to the latter number.
- Dr. Wohl noted there were higher testing rates for syphilis than for Chlamydia or gonorrhea among all groups. There is a better effort to test for all three morbidities among those 18-29, but still a higher rate for syphilis. The rates highlight areas for improvement. Testing data was from both routine and patient-initiated screening.
- Mr. Pérez noted there are performance thresholds for approximately 21 areas as part of the initiation of FFS for all Ryan White partners. One area is how well they screen for Hepatitis C Virus (HCV), syphilis, gonorrhea and Chlamydia. The Threshold for Compliance (TFC) is screening at least once since the diagnosis of HIV for at least 90% of patients. DHSP has increased THC to 100% for HCV and syphilis and to 94% for gonorrhea and Chlamydia. This is a good example of how tying reimbursement to performance measures is important to improving health care.
- Nationally, HEDIS measures are used by health plans to determine whether or not they provide a service and how they rank vis-à-vis other plans. Chlamydia has been added to the HEDIS measure list, so testing will increase. Syphilis and gonorrhea, however, are not on the list so the County will need to partner not only with Federally Qualified Health Centers (FQHCs) and Community Health Centers (CHCs), but also with private practitioners to improve screening.

- There is likely not a financial incentive for private practitioners to increase screening and the moral imperative is unlikely to be sufficient. There will need to be structural interventions developed to increase rates.
- The goal of Partner Services is to interrupt STD transmission through timely interview of index cases and treatment of their sexual partners. Laboratories and providers report index cases to DHSP.
- Reports are prioritized and assigned to Public Health Investigators (PHIs) by disease type and demographic factors. Approximately 75% of reported cases in the County are Chlamydia, but there is a shared national policy approach, including by the CDC, to invest limited public health STD resources in gonorrhea and syphilis control, especially early syphilis when people are most infectious. Cases that involve HIV and or a pregnant woman are also high priority.
- PHIs conduct field interviews with index cases to ensure treatment, offer linkage-to-care and elicit sexual contact information. Many contacts today say they have had, e.g., 32 partners in the last 12 months, know three by name, met 20 online and 10 at clubs. PHIs follow-up with sexual contacts as well as possible. They work throughout the County in such settings as jails, mobile clinics, 12 County STD clinics and other non-County high-morbidity clinics.
- Regarding reporting, Mr. Pérez said the County has a list of diseases with mandatory reporting criteria. Providers may be required to call or may mail a report within one, seven or thirty days. Partners are not included.
- The County branched out from the DPH PHI model several years ago and launched Community Embedded Disease Intervention Specialists (CEDIS). It was expected people would be more comfortable with a trusted community-based sexual health partner to be treated, return for follow-up, name partners and bring them in for treatment.
- CEDIS are trained to the PHI standard, but employed and located in high-morbidity clinics. In SPA 4 there are two at GLC and one at AHF. Supervisorial District 2 has three to address gonorrhea at ten high-morbidity clinics. CEDIS offers multiple advantages, including faster interview of index cases and fewer lost to follow-up, more partners elicited and interviewed per session and faster treatment of partners, with more partners treated.
- A few months ago, DHSP was discussing how to better understand the infection cycles, e.g., how many people are infected with syphilis annually, how many are screened, treated and interviewed. The discussion led to the idea of an STD cascade similar to that for HIV. Dr. Wohl and Mr. Murphy triangulated multiple data sets to develop it and both the State and CDC are impressed. This tool will eventually help everyone, not just the County, improve STD response.
- There were 11,454 gonorrhea cases reported in 2012 with 19% reported from a County-run clinic/hospital and 80% reported from the private sector. Approximately 88% were treated with 28% of those treated in a County-run clinic/hospital. Approximately 74% of cases were assigned for investigation, with 34% interviewed and with 15% of cases interviewed identifying at least one partner—not including provider-delivered partner services.
- There were 2,093 partners identified via the 15% of cases that identified a partner. Of those partners, 80% (1,669) were located, 73% (1,525) were notified, 30% (635) were examined and 27% (558) were treated.
- Mr. Pérez noted the challenge in these declining numbers through to partner identification and treatment versus the balance of cases. Yet, as noted earlier, the CDC is allocating $3.5 million for STDs versus $90 million for HIV.
- The 3,105 reported syphilis cases in 2012 show a similar pattern with 19% reported from a County-run facility. Approximately 93% were treated with 47% of those treated in a County-run facility. Approximately 97% of cases were assigned for investigation with 77% interviewed and 30% of cases interviewed identifying at least one partner, not including provider-delivered partner services. Some factors influence higher investigation rates for syphilis, e.g., it is often part of HIV co-infection and cases in women are investigated to avert congenital syphilis.
- There were 1,559 partners identified via the 30% of cases that identified a partner. Of those partners, 85% (1,322) were located, 75% (1,173) were notified, 41% (632) were examined, and 32% (505) were treated.
- Part of case study information is a form of network map that shows one person with spokes to other people who, in turn, may be the starting point for spokes to still others. Staff develops pictures of what is happening on the ground, e.g., people may be connected as part of the same social or sexual network.
- Dr. Wohl noted this just completed data took months to compile, e.g., to identify percentages ofr County reported and treated cases. The next step will be to develop gender, race/ethnicity, age and geography demographic data.
- Mr. Pérez said there were 2,158 cases of Early Syphilis (ES) in 2012 with a rate of 21.8 per 100,000. Morbidity is highly concentrated by demographic and geographic factors: 77%, MSM/MSMW; 43%, SPA 4; 19%, diagnosed at GLC and 5% at AHF's Men's Wellness Center in Hollywood. Approximately 60% of MSM/MSMW with ES are HIV+.
- DHSP also recently spoke with Dr. Kushner, the new Health Officer, City of Long Beach, to improve response there.
- CEDIS are one of the three PHI models. They are non-County, community-based organization hired employees trained by DHSP. They follow-up index cases at a single site with contact tracing by phone, text and mail. They

refer complicated or hard to find cases to DHSP. They are, and are viewed as, clinic staff. Some CEDIS staff had requested County emails, but Mr. Pérez declined precisely because the value is in being community-based.

- District PHIs are employed by the Department of Health Services (DHS) and located at the 12 County STD clinics. They follow-up with index cases at a specific clinic as well as non-clinic index cases in a health district. They do contact tracing by phone, text, email and field investigation. They are viewed as DHS/clinic staff.
- DHSP PHIs are employed by and located at DPH. They follow-up on "high" priority index cases throughout the County. They also do contact tracing by phone, text, email and field investigation. They are viewed as DHSP staff.
- A comparison of how quickly ES cases are interviewed by CEDIS, District PHIs and DHSP PHIs shows CEDIS complete interviews most quickly. Comparing partners elicited per case: CEDIS, 1.04; District PHIs, 0.45; DHSP PHIs, 0.28. Comparing partners interviewed per case: CEDIS, 0.47; District PHIs, 0.21; DHSP PHIs, 0.09.
- Data supports the CEDIS model which engenders greater trust due to its base in the community.The CEDIS program in SPA 4 for ES is associated with fast interview of ES cases/partners and significant numbers of ES partners identified/interviewed/treated leading to interruption of ES transmission.
- Staff turnover at clinics can limit CEDIS efficacy, however, and CEDIS does not reach cases that do not access clinical services. Many PHI clients are also more difficult to reach due to underlying demographic differences.
- Mr. Pérez noted the high STD rates in Supervisorial District 2 (SD2), specifically extremely high rates of gonorrhea, 35%, and Chlamydia, 34% as a proportion of County cases in 2012. African-American women, aged 15 to 24, in SD2 had gonorrhea rates ten times higher and Chlamydia rates four times higher than white women, aged 15 o 24, in SD2. Gonorrhea and Chlamydia rates were four to five times higher for young African-American than for young white men in SD2.
- In response to this data, Supervisor Mark Ridley-Thomas and DPH convened a Community Advisory Coalition (CAC). CAC is developing a community strategic plan for SD2 to reduce STD numbers and address disparities.
- Mr. Pérez identified future directions for the STD response:
  - Fully map out STD burden in the County including demographic data;
  - Increase public and private sector STD screening capacity and volume, e.g., create incentives, policy interventions and structural interventions;
  - Increase targeted STD screening;
  - Reduce gaps in partner services activities;
  - Enhance CEDIS activities;
  - Complete current targeted STD strategic planning efforts and begin countywide planning efforts;
  - Continue to develop synergies between HIV and STD activities.
- Mr. Liso asked about Human Papilloma Virus (HPV), also an STD; he considered it a key indicator. Mr. Pérez noted there is a very effective HPV vaccine and there are many STDs. DHSP addresses a number of them not discussed here, but efforts are minimal due to resource limitations. It is critical to enlist community partners in the effort.
- Kimler Gutierrez noted Los Angeles has the highest Asian/Pacific Islander (A/PI) population of any county in the United States. The first slide reflected A/PIs, but later analysis was inconsistent. Surveillance is important especially in regards to Hepatitis. Mr. Pérez said rates are much lower for A/PIs and Native Americans so they are sometimes dropped rather than be represented by just a line. DHSP will work to include richer data going forward.
- Dr. Spencer offers annual STD lectures for County pediatric providers who are always surprised at rates, especially high Chlamydia rates among young women, its morbidity, mortality and infertility. More education is needed.
- Mr. Land asked what other funds, such as Net County Cost (NCC), will be added to the CDC STD funding of $3.5 million. Mr. Pérez replied there is no Maintenance of Effort comparable to the $18 million tied to the Ryan White grant which precludes the County from reducing the amount. Funds are identified for public health programs and services from a variety of sources, e.g., the vehicle license fee, and as a result, they fluctuate. This year NCC will be $3 million.
- Supervisor Ridley-Thomas is augmenting resources to address STDs in SD2 from his office funds, but Mr. Pérez noted resources alone are ineffective. It is critical to review: capacity; motivation; willingness; community norms to promote sexual health; how young people consume sexual health services or health care generally; and what is said at school, home and in church. A concerted community response is needed, which is why CAC was formed.
- Mr. Johnson was shocked during his time at Planned Parenthood to see how many pediatricians asked for help in talking to patients about sexual health. They had often treated a patient since birth who was now 16 and had had Chlamydia three times. As people move into managed care, it is critical to prioritize and allocate resources to provider education, including learning how to effectively share our expertise with managed care systems.

- Ms. O'Malley added providers have just 15 minutes, but she is still shocked at how many complete an entire history and physical without mentioning sexual health, even to her. When she raised it, her provider was unsettled. She is the sex educator for her children's private, Christian school. It can be done in a respectful way.
- Dr. Wohl said DHSP is participating in the SD2 CAC strategic plan process. One low-hanging fruit suggested by the CDC was to educate providers who already see young African-American men and women. PHIs and CEDIS can go out and talk with them about the importance of STD screening. She advised that showing them the graphs is useful; they speak for themselves.
- Dr. Younai noted Dr. Torrez Ruiz, University of California at Los Angeles, developed "60 Second Sexual Risk Assessment" videotapes in the 1990s. Tapes were used to train physicians to comfortably assess sexual health in under a minute using a question/answer format. The School of Dentistry has used the tapes and students are screening patients. Tapes are targeted to HIV, but AETC could develop similar modules for STDs.
- Ms. Holloway asked Dr. Wohl why African-American rates are high if it was felt they were not being tested in sufficient numbers. Dr. Wohl replied if a concentrated area has a high transmission rate then there are people who are not being tested/treated who are transmitting the disease. A basic public health response is to increase testing.
- Diagnoses will increase initially, but decline as people who were transmitting the disease are identified and treated. There is likely under-reporting among all races/ethnicities, but people are more likely to engage in sexual behavior with their own race/ethnicity. The CDC has noted STD rates are lower for young African-American women in the County, specifically for gonorrhea and Chlamydia, than nationally, especially in urban areas.

➲ Mr. Pérez committed to providing case studies including both men and women to reflect infection patterns.
➲ Mr. Pérez will report back on meningitis in the future.
➲ Mr. Pérez will provide a break-out of testing site test data by morbidity.

12. CALIFORNIA OFFICE OF AIDS (OA) REPORT:

A. OA Work/Information:

- Ms. Kiburi, Chief, HIV Care Branch, reported the California Department of Public Health has clarified that as of 1/1/2014 local health department staff can use locally acquired HIV surveillance data to identify individuals infected with HIV and offer them partner services. OA is identifying how to provide Technical Assistance. The document is on the OA website.
- OA submitted its 2014 Ryan White Part B Funding Opportunity Application to HRSA on 12/5/2014.
- OA staff is developing a comparison chart of antiretroviral medications for Covered California formularies. Eleven of 12 plans have been reviewed plus the Alameda Alliance for Health, not yet part of the network. The Kaiser formulary will be added when available. The chart will be posted soon on the OA website and provided to ADAP Enrollment Workers.
- OA released a letter on 11/27/2013 to all ADAP clients with information on Medi-Cal Expansion and Covered California, including information on eligibility, how and where to apply and two new health programs available 1/1/2014. The advisory committee and several people from the stakeholder community reviewed most information before release.
- The Insurance Assistance Section released a similar letter to all Pre-Existing Condition Insurance Plan (PCIP) clients on 12/2/2013 that informs them the PCIP program will end 12/31/2013. The letter also provides eligibility and application information for Medi-Cal Expansion and Covered California.
- ADAP released Management Memo No. 2013-17 to all ADAP Coordinators and Enrollment Workers on 12/3/2013. The memo offers eligibility criteria and enrollment information for Medi-Cal Expansion and Covered California. It includes OA policies and procedures on how to enroll clients who obtain health coverage through Covered California into the OA-Health Insurance Premium Payment Program (OA-HIPP) program. A copy of the 11/27/2013 letter is included.
- Mr. Kelly referenced a recent *Wall Street Journal* article on the ACA and drug formularies, including once-per-day Atripla which is not always included or has varied pricing. He asked how that impacts allocation of funds for ADAP.
- Mr. McMillin asked about recently implemented changes to the OA-HIPP application form. A section was added with questions for those entering Covered California that must be answered for the application to be processed. He also wanted to ensure the OA-HIPP application would be widely available to first-time Covered California enrollees.
- Mr. Land asked whether OA will be hiring more staff to speed up the OA-HIPP application process. Ms. Kiburi replied OA recently had a HRSA site visit that focused on how ADAP was administered. One recommendation was to add staff and there was support for identifying how to do so. OA is working on the issue internally.

➲ Ms. Kiburi will follow-up on the status and pricing of Atripla for ACA plans and provide a written report.
➲ Ms. Kiburi will follow-up on the OA-HIPP application changes and distribution and provide a written report.
➲ Ms. Kiburi will ask Niki Dhillon, Chief, ADAP Branch, to provide an update on plans to add OA-HIPP staff.

B. California Planning Group (CPG):

1. ***Member Recruitment***:

- Ms. Kiburi said OA is recruiting members for the new CPG term. There has been outreach to all the care and prevention planning councils as well as for general membership. Each Part A planning council has a seat and applications have been received from all except Los Angeles, Riverside/San Bernardino and San Jose/Santa Clara.
- The nine Part A applicants to date represent a fairly good demographic balance except for Latinos and MSM of color. With that in mind, OA would prefer an African-American or Latino MSM candidate.
- OA is working to improve the CPG by ensuring optimal membership and reducing the time commitment to enhance efficiency and minimize the burden on members. Basic participation requirements are two in-person meetings per year assuming funding for travel expenses and two webinars per year. Terms are three years. If needed, there may be additional teleconferences, but they will be kept to a minimum.
- The CPG includes voting and non-voting members. Full planning council participation is important as OA would like the CPG to: participate more fully in developing the Statewide Coordinated Statement of Needs; help monitor meeting Integrated Surveillance, Prevention and Care Plan goals and objectives; help develop letters of concurrence for HIV prevention planning; and to harmonize and align OA Care, HRSA and CDC prevention goals and objectives.
- Nominees put forward for the Commission's CPG seat were: Messrs. Ballesteros, Rivera, Smith and Zaldivar. Mr. Ballesteros declined the nomination in favor of the other nominees.
- Ms. Kiburi requested application submission by 1/23/2014 when OA will review general member applications and make final decisions. The application was in the packet and available electronically from Commission staff.
- OA would also appreciate an MSM of color or transgender volunteer to help review general member applications. There is one transgender general member applicant so far. Planning council nominees are seated automatically.
- ➲ Mr. Ballesteros offered to review general member applications. Staff will provide OA with his contact information.
- ➲ The Brown Act requires elections to be posted in advance so the Commission will ratify the vote at its next meeting. Results can move forward, but Commissioners should recall how they voted and why for the ratification.

MOTION 5A: Elect Juan Rivera as the Commission representative to the California Planning Group (CPG) for a three-year term ***(Rivera, 15; Smith, 11; Zaldivar, 0; Abstentions, 2)***.

13. **STANDING COMMITTEE REPORTS**:

A. Planning, Priorities and Allocations (PP&A):

1. ***Financial Expenditure Reports***: Mr. Land noted the reports in the packet reflect how allocations are being utilized.

2. ***FY 2013 Allocation Revisions***: Commissioners stated their conflicts of interest.

- There is a three-part review process each year to evaluate how effectively resources are allocated, and how well expenditures align with allocations. The first review occurs when the Ryan White Part A award is finalized and the second when the Part B/Single Allocation Model (SAM) award is finalized. The third review occurs towards the end of the year to evaluate how well resources are being utilized/expended. Revisions are made when allocations cannot be utilized as anticipated, or there are other significant discrepancies between expenditures and allocations.
- The "Modification to Fiscal Year 2013 Ryan White Parts A/B Allocations" memorandum in the packet detailed recommended revisions to increase and decrease allocations as summarized below:
  - **Increase Medical Care Coordination (MCC) by 4.5%**: DHSP's full-year expenditure estimate exceeds the original allocation by 4.5%. MCC contracts were fully executed in FY 2012 and most agencies have fully implemented MCC for most of FY 2013. MCC replaces most medical and non-medical case management. A few non-medical case management contracts at agencies not affiliated with medical providers remain in FY 2013, but are being converted to Linkage To Care services in FY 2014.
  - **Increase Benefits Support by 0.5%**: DHSP estimates expenditures for benefit specialists will exceed the FY 2013 allocation. Further, most work under the legal services contract, extended for a year to close remaining cases, entails legal representation in benefits appeals, which PP&A felt should be funded via Benefits Support rather than NCC. Finally, possible solutions to cover non-premium cost-sharing requirements for Ryan White patients who enroll in Covered California would be funded via Benefits Support, if implemented.
  - **Decrease Oral Health by 2.0%**: Phase II expansion remains underway, but has progressed at a slower pace than expected and current providers have capacity for additional patients. Providers are also spending less per

patient than anticipated. Consequently, DHSP anticipates underspending for FY 2013. FY 2014 allocations continue to reflect an increase for Phase III of the expansion until such time as trends indicate it is not needed.

- **Decrease Substance Abuse, Residential by 0.5%**: DHSP estimated underspending.
- **Decrease Linkage To Care (LTC) by 1.0%**: DHSP and SBP are readying the service delivery network to launch LTC services. SBP will complete the standard in FY 2014 and DHSP will then procure services beginning with conversion of remaining non-medical case management contracts to LTC in early FY 2014, which had been anticipated in FY 2013. Other LTC services will be paid with Minority AIDS Initiative (MAI) funds. With no prospects for additional LTC services for the remainder of FY 2013, PP&A chose to eliminate the entire 1.0% allocation.
- **Decrease Optometry by 1.0%**: HRSA added implementation delay by restricting the service definition to specific HIV-related causes, which may require funding it through NCC. The highly scrutinized County procurement process has also slowed third-party administrator solicitation. Consequently, the service cannot be launched in FY 2013. PP&A chose to eliminate the entire 1.0% FY 2013 allocation. The FY 2014 allocation remains intact.
- **Decrease Long-Term and Palliative Care (LTPC) by 0.5%**: Hospice and skilled nursing are both underutilized. There are no hospice patients and no contracted facilities. Skilled nursing services are housed at Residential Care Facilities for the Chronically Ill, funded under residential services. PP&A chose to eliminate the entire 0.5% allocation as redundant with the residential services allocation.

- Mr. Ballesteros noted the recommended decreases balance the recommended increases for a total 5.0% revision.
- Mr. Kelly noted these revisions were presented to the PP&A when it was relatively new. Only four of the twelve members were familiar with the process, so he felt it helpful that the Executive Committee reviewed the revisions. He felt the memorandum should reference the ability of DHSP to modify allocations within certain limits though the recommended revisions fall outside that authority. He also felt the memorandum should verify that the revised allocations continue to meet HRSA's requirement for 75% of funds to be expended on core medical services.
- As explanation of Mr. Kelly's recommendation, Mr. Ballesteros said the Commission gave DHSP in FY 2011 the authority to adjust amounts allocated to service category line items by up to 10% of the service category allocation, recognizing that there may be immediate adjustments needed by the grantee that cannot wait for PP&A and Commission review. He noted that it was referenced on page 3 of the memorandum.
- Mr. Stewart clarified that this action has already been taken by the Executive Committee under its power to act when something needs to happen in a shorter timeframe than the schedule allows. Due to the Annual Meeting, these PP&A recommendations could not be returned to the full Commission until after a date that they would be effective. The ratification is, therefore, a yes or no vote that conveys the Commission's agreement or disagreement with the action the Executive Committee took on their behalf.

➲ Future memorandums will document alignment with the HRSA mandated 75% allocation to core medical services.

MOTION 6: Ratify Executive Committee's approval, on behalf of the Commission, of revisions to FY 2013 Allocations ***(Passed: 26 Ayes; 0 Opposed; 2 Abstentions)***.

B. Operations: The next meeting has been rescheduled to 12/16/2013, 10:00 am to 12:00 noon, due to the holidays.

1. ***Membership Changes/Additions***: Mr. Green noted there will be a few changes in the coming months as a result of job changes that affect eligibility for certain seats.
2. ***Conflict of Interest Policies***: This item was postponed as the Ryan White and State policies were unavailable for review.

C. Public Policy:

1. ***Affordable Care Act (ACA) Implementation***:
   - Mr. Zaldivar said the Public Policy Committee continues to follow the ACA, but nothing new is expected pending implementation.
   - Mr. Land said he assisted an individual with Covered California enrollment recently. He found the application both cumbersome and challenging, e.g., it is difficult to navigate for a PLWH who needs to understand medications and other aspects of care. He suggested the Commission advocate for a "people with disabilities" tab.
2. ***Commission 2014 Legislation Agenda***: This item was postponed.
   MOTION 7: Approve the Commission's 2014 Legislative Agenda, as presented ***(Postponed)***.
3. ***Federal FY 2013-2014 Budget***: Despite some preliminary agreements, the budget is still under discussion.

D. Standards and Best Practices (SBP): Mr. Land encouraged SBP members to participate in the Priorities-and-Allocations (P-and-A) process. Their insights and suggestions on service categories and utilization patterns are valued. Mr. Johnson added participating in the P-and-A process offers an excellent education on and overview of much of the Commission's work.

1. ***LA County Continuum of HIV Care/Services***:
   - Dr. Younai said SBP is developing several papers. One focuses on the County's HIV continuum and will address its evolution since the first Continuum of HIV Care was developed in 2007-2008 and how it will change under ACA.
   - A second paper will address social determinants of care which impact how people move through the continuum.
   - The new diagram for the continuum in the packet reflects both of these areas. The patient flow map section pertains to the treatment cascade from prevention through adherence to care while social determinants are reflected in how individuals interact with systems. There will be more discussion of the diagram at a later date.
2. ***Format of Standards of Care Summary***: Dr. Younai reported SBP has begun consolidating the 28 standards into fewer, more user-friendly documents. Executive summaries are also being developed to serve as a quick reference.

14. CAUCUS REPORTS:

A. Consumer Caucus:
- Mr. Liso reported the Caucus last met 11/14/2013. Discussion topics included recertification, the ACA and OA-HIPP issues. Dr. Karen Mark, Division Chief, OA, attended and actively listened to all issues raised.
- The next meeting will follow the Commission meeting and address ongoing issues such as OA-HIPP.

1. ***Policy/Procedure #09.7201: Consumer Compensation***: This item was postponed..
   MOTION 8: Approve Policy/Procedure #09.7201: Consumer Compensation, as revised and presented following public comment period ***(Postponed)***.

B. Latino Caucus: The Latino Caucus did not meet.

C. Transgender Caucus:
- Ms. Enfield reported the Caucus met on 10/24/2013. Discussion topics included subjects for future focus, including the ACA, community needs such as hormone replacement therapy, and special population guidelines.
- The Caucus also addressed community readiness in the County at large and on the Commission. It is considering developing a "TG 101" to clarify misunderstandings and help everyone get on the same page.
- The importance of developing better data to address unmet need was also discussed. The Caucus considered how the Los Angeles Coordinated HIV Needs Assessment (LACHNA) might be used to improve data collection.
- Mr. Zaldivar, Co-Chair, Public Policy, thanked the transgender community for its representation on the Committee. He encouraged the Caucus to provide input on issues it would like Public Policy to address.

15. TASK FORCE REPORTS:

A. Community Engagement Task Force: There was no report.

B. Corrections Task Force:
- Mr. Avilez asked when the Task Force would begin meeting. Mr. Vincent-Jones replied the intention had been to start in January 2014 but, after three or four requests, only two people have volunteered to date.
- ➲ The Co-Chairs will begin appointing members after the holidays if additional volunteers do not step forward.

C. Community Task Forces: There was no report.

16. CITY/HEALTH DISTRICT REPORTS: This report will launch at the next meeting.

17. HOUSING OPPORTUNITIES FOR PERSONS WITH AIDS (HOPWA) REPORT: This report will launch at the next meeting.

18. AIDS EDUCATION/TRAINING CENTERS (AETC): There was no report.

19. SPA/DISTRICT REPORTS: There was no report.

20. COMMISSION COMMENT: There was no report.

21. ANNOUNCEMENTS: There was no report.

22. ADJOURNMENT: The meeting adjourned at 1:40 pm.

A. Roll Call (**Present)**: Ballesteros, Cataldo, Ferlito, Garbutt, Geniess, Goddard, Granados, Green, Anthony Gutierrez, Johnson/Donnelly, Kelly, Kochems, Land, Lester, Liso/Lantis, Lopez, McMillin, Morales, Munoz, Palmeros, Pérez, Rivera, Rosales, Rotenberg, Samone-Loreca/Forrest, Tula, Younai, Zaldivar

MOTION AND VOTING SUMMARY		
MOTION 1: Approve the Agenda Order.	***Passed by Consensus***	**MOTION PASSED**
MOTION 2: Revise and approve the minutes from the April 11, 2013 Joint Commission on HIV/Prevention Planning Committee (PPC) meeting, the October 10, 2013 Commission on HIV meeting and the November 14, 2013 Commission on HIV Annual Meeting, as presented.	***Postponed***	**MOTION POSTPONED**
MOTION 3: Approve the Consent Calendar.	***Postponed***	**MOTION POSTPONED**
MOTION 4: Approve Policy/Procedure #08.2107: Consent Calendar, as revised and presented following public comment period.	***Postponed***	**MOTION POSTPONED**
MOTION 4A (*Zaldivar/Rosales*): Move discussion on CPG representation to later in the agenda.	***Passed by Consensus***	**MOTION PASSED**
MOTION 5: Approve amendments to Policy/Procedure #06.1000: Commission on HIV Bylaws, as revised and presented following public comment period.	***Passed by Consensus***	**MOTION PASSED**
MOTION 5A: Elect Juan Rivera as the Commission representative to the California Planning Group (CPG) for a three-year term.	***Rivera:*** Ballesteros, Cataldo, Ceja, Garbutt, Goddard, Green, Anthony Gutierrez, Johnson, Kochems, Land, Lopez, McMillin, Palmeros, Rivera, Tula ***Smith:*** Enfield, Geniess, Granados, Holloway, Kelly, Liso, Rotenberg, Samone-Loreca, Rosales, Tran, Zaldivar ***Zaldivar:*** None ***Abstention:*** Kiburi, Pérez	**MOTION PASSED** **Rivera:** 15 **Smith**: 11 **Zaldivar**: 0 **Abstentions**: 2
MOTION 6: Ratify Executive Committee's approval, on behalf of the Commission, of revisions to FY 2013 Allocations.	***Ayes:*** Ballesteros, Cataldo, Enfield, Garbutt, Geniess, Goddard, Granados, Green, Anthony Gutierrez, Holloway, Johnson, Kelly, Kochems, Land, Liso, Lopez, McMillin, Munoz, Palmeros, Rivera, Rosales, Rotenberg, Tran, Tula, Younai, Zaldivar ***Opposed:*** None ***Abstentions:*** Kiburi, Pérez	**MOTION PASSED** **Ayes**: 26 **Opposed**: 0 **Abstentions**: 2
MOTION 7: Approve the Commission's 2014 Legislative Agenda, as presented.	***Postponed***	**MOTION POSTPONED**
MOTION 8: Approve Policy/Procedure #09.7201: Consumer Compensation, as revised and presented following public comment period.	***Postponed***	**MOTION POSTPONED**